

Policy ID / Principal's Membership Number

PLEASE ENSURE THAT ALL RELEVANT SECTIONS ARE COMPLETED.

IMPORTANT: COMPLETE & RETURN THIS FORM, BEFORE YOUR THIRD TRIMESTER. Email to: claims@healthintergrp.com AND kudzi@healthintergrp.com.

SECTION 1 - MEMBERSHIP PLAN OF PRINCIPAL MEMBER (TICK AS APPROPRIATE)

Diamond Plan

Emerald Plan

SECTION 2 - PERIOD OF CURRENT MEMBERSHIP POLICY

From: DD / MM / YYYY

To: DD / MM / YYYY

SECTION 3 - PRINCIPAL MEMBER'S DETAILS

Surname: Title:

First Name(s):

Residential Address:

Mobile: Residential Tel: Business Tel:

Email: Company Name:

SECTION 4 - BABY DETAILS

Surname (if different from Principal Member):

Intended Country of Birth:

SECTION 5 - PREGNANCY DETAILS

Estimated Date of Delivery (EDD): DD / MM / YYYY

Current gestational age (weeks):

Is this a multiple pregnancy? e.g. twins / triplets YES NO

Was this pregnancy achieved through medical / assisted reproductive support? YES NO

If YES, please briefly specify the type of assisted conception treatment, e.g. Clomid, IUI, IVF

Name of your G.P. / Gynecologist?

Name of healthcare facility where the delivery is planned?

REQUIRED POST DELIVERY:

Full Name; Gender; Date of Birth; Copy of Birth Certificate; Copy of Photo Identification (when available)

SECTION 6 - DECLARATION (PLEASE READ CAREFULLY)

1. On behalf of myself, the principal applicant, and for each person included on this application, I authorise the aforementioned cited doctors to provide Health International with such information as they may seek in connection with this application.
2. I authorise Health International to have unrestricted access to my medical records and the medical records of each person included on this application, but require their confidentiality to be maintained.
3. I understand that any false statement made in this document or the non-disclosure of any material information may render the membership null and void.
4. I understand that any condition for which I or any person included on this application have received medical advice or treatment at any time in the past may be excluded from the benefit.
5. I agree to accept written communications from the authorised representatives of Health International of any conditions excluded from the benefits.
6. I accept I will have to refund to Health International any benefit paid out but not covered by the Terms and Conditions.
7. I understand that Health International will collect and process my personal data as per Clause 9.10 of the Terms and Conditions.

IT IS THE PRINCIPAL MEMBER'S RESPONSIBILITY TO ADVISE HEALTH INTERNATIONAL OR THEIR AGENT OF THE BABY'S DATE OF BIRTH, NAME AND GENDER.

DECLARATION OF APPLICANT

I confirm that I have been provided with a copy of the Terms & Conditions (either in hard copy, soft copy or via access to the website) and that I have read, understood, and agree to be bound by them. I acknowledge that the Terms & Conditions may be updated from time to time and that I will be notified of any changes, in writing, via the Important Changes document, at the time of my policy renewal. It is my responsibility to review the latest version available.

Principal Applicant Signature* _____ Date (DD / MM / YY) _____

** IMPORTANT: This application form must be signed by the PRINCIPAL APPLICANT. No other signature will be accepted.*

AUTHORISED REPRESENTATIVES OF HEALTH INTERNATIONAL

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